		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010678

Facility Name: Winchester House

Address: 1125 N. Milwaukee (Number) Libertyville (City) 60031 (Zip Code)

County: Lake

Telephone Number: 847-377-7236 **Fax #** 847-816-5168

IDPA ID Number: 36 6006600

Date of Initial License for Current Owners: Before 1941

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Joan Bodenlos, Assistant Administrator **Telephone Number:** 847 377 7236

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2000 to 11/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Stephen Nussbaum

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) 847-377-7341 Fax # 847-816-5168

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 11/15/1999

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	360	Skilled (SNF)	360	131,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	360	TOTALS	360	131,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,811	2,580	801	13,192	8
9	SNF/PED					9
10	ICF	79,019	30,734		109,753	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	88,830	33,314	801	122,945	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.57%

D. How many bed-hold days during this year were paid by Public Aid?
680 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Employee meals, Non-Resident laundry

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1941

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 144

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [X] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [N/A]

Tax Year: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	1,068,826	80,219	350	1,149,395		1,149,395		1,149,395			1
2	Food Purchase		549,919		549,919	(51,254)	498,665	(34,975)	463,690			2
3	Housekeeping	746,566	91,709	8,851	847,126		847,126	2,824	849,950			3
4	Laundry	380,596	17,302	2,491	400,389		400,389	(22,641)	377,748			4
5	Heat and Other Utilities			575,862	575,862		575,862		575,862			5
6	Maintenance	566,762	138,501	198,394	903,657		903,657		903,657			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,762,750	877,650	785,948	4,426,348	(51,254)	4,375,094	(54,792)	4,320,302			8
	B. Health Care and Programs											
9	Medical Director			16,008	16,008		16,008		16,008			9
10	Nursing and Medical Records	6,348,598	354,576	194,474	6,897,648	(30,442)	6,867,206	(17,869)	6,849,337			10
10a	Therapy	314,528	1,002	63,775	379,305		379,305		379,305			10a
11	Activities	436,523	24,185	1,931	462,639		462,639		462,639			11
12	Social Services	176,704	1,340	1,526	179,570		179,570		179,570			12
13	Nurse Aide Training					50,242	50,242	2,241	52,483			13
14	Program Transportation	109,825	1,660	355	111,840	3,878	115,718		115,718			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,386,178	382,763	278,069	8,047,010	23,678	8,070,688	(15,628)	8,055,060			16
	C. General Administration											
17	Administrative	171,835			171,835		171,835		171,835			17
18	Directors Fees											18
19	Professional Services			11,362	11,362		11,362		11,362			19
20	Dues, Fees, Subscriptions & Promotions			21,440	21,440	1,000	22,440		22,440			20
21	Clerical & General Office Expenses	577,402	36,088	696,026	1,309,516		1,309,516		1,309,516			21
22	Employee Benefits & Payroll Taxes			1,453,267	1,453,267	51,254	1,504,521	1,588,550	3,093,071			22
23	Inservice Training & Education											23
24	Travel and Seminar			64,665	64,665	(24,678)	39,987	(29,221)	10,766			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	749,237	36,088	2,246,760	3,032,085	27,576	3,059,661	1,559,329	4,618,990			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	10,898,165	1,296,501	3,310,777	15,505,443		15,505,443	1,488,909	16,994,352			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Winchester House #0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							536,145	536,145			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**							536,145	536,145			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	158,015	961,850	431	1,120,296		1,120,296	(403)	1,119,893			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							197,100	197,100			42
43	Other (specify):*		91,066		91,066		91,066		91,066			43
44	**TOTAL Special Cost Centers**	158,015	1,052,916	431	1,211,362		1,211,362	196,697	1,408,059			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	11,056,180	2,349,417	3,311,208	16,716,805		16,716,805	2,221,751	18,938,556			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	34,975	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	19,027	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 54,002		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,523,780		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,523,780		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,577,782		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology	x		1,650	10	42
43	Prescription Drugs					43
44	Exceptional Care Program	x		7,542	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 9,192		47

Winchester House

ID# 0010678

Report Period Beginning: 12/1/2000

Ending: 11/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Winchester House # 0010678 **Report Period Beginning:** 12/1/2000 **Ending:** 11/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	34,975	0	0	0	0	0	0	0	0	0	0	34,975	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	19,027	0	0	0	0	0	0	0	0	0	0	19,027	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	54,002	0	0	0	0	0	0	0	0	0	0	54,002	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	1,523,780	0	0	0	0	0	0	0	0	0	1,523,780	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	1,523,780	0	0	0	0	0	0	0	0	0	1,523,780	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	54,002	1,523,780	0	0	0	0	0	0	0	0	0	1,577,782	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Winchester House** **#** **0010678** **Report Period Beginning:** **12/1/2000** **Ending:** **11/30/2001**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**54,002**	**1,523,780**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,577,782**	**45**

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
County of Lake	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		22	FICA	$	County of Lake	100.00%	$ 834,919	$ 834,919	1
2	V		22	IMRF		County of Lake	100.00%	103,477	103,477	2
3	V		22	Workmans Compensation		County of Lake	100.00%	413,502	413,502	3
4	V		22	Unemployment Compensation		County of Lake	100.00%	50,264	50,264	4
5	V		22	Liability Insurance		County of Lake	100.00%	121,618	121,618	5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$ 1,523,780	$ * 1,523,780	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: ######

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: County of Lake
Street Address: 18 North County Street
City / State / Zip Code: Waukegan, IL 60085
Phone Number: (8473606601
Fax Number: (8473606592

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Direct Cost				$ 610,818	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 610,818	$		$	25

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ Not Applicable	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ NA	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ NA	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winchester House COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0010678

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 189,077 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		522,720	Prior 1941	$ 5,466	1
2					2
3	TOTALS	522,720		$ 5,466	3

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	360		1972	1971	$ 5,306,095	$ 132,654	40	$ 132,654	$	$ 3,718,108	4
5			1960	1959	503,487		40			503,487	5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Expansion			1972	31,454	786	40	786		23,590	9
10	Dishroom Addition			1978	44,855	1,121	40	1,121		26,912	10
11	Concrete Stoop			1982	875	35	25	35		700	11
12	Smoke Detectors			1982	7,260	290	25	290		5,807	12
13	Roofing Improvement			1984	41,875	1,675	25	1,675		30,150	13
14	Vestibule Improvement			1984	41,321	1,033	40	1,033		18,594	14
15	Storage Building			1987	9,986	499	20	499		7,489	15
16	Sprinkler System			1987	51,732	2,069	25	2,069		31,040	16
17	Reroof Building A			1987	15,393	770	20	770		11,545	17
18	Repipe Steamline			1987	22,270	891	25	891		13,362	18
19	Redecorate Hallways			1987	105,483	4,219	25	4,219		63,289	19
20	Dining Room Alteration			1987	120,602	4,824	25	4,824		72,361	20
21	Folding Gate			1987	1,961	130	15	130		1,961	21
22	Boiler Renovation			1988	11,600	464	25	464		6,496	22
23	Parking Expansion			1988	50,384	3,359	15	3,359		47,025	23
24	Steel Doors			1989	9,300	620	15	620		8,060	24
25	Air Conditioning 2nd Floor			1989	30,435	2,029	15	2,029		26,377	25
26	Parking Lot Expansion			1989	6,121	408	15	408		5,305	26
27	Smoke Dampers			1989	27,520	1,835	15	1,835		23,851	27
28	Air Conditioning 3rd Floor			1990	49,807	3,320	15	3,320		39,845	28
29	Flooring			1990	6,200	413	15	413		4,959	29
30	Electrical Improvement			1990	7,925	528	15	528		6,339	30
31	Asbestos Removal			1990	29,985	1,999	15	1,999		23,988	31
32	Nursing Station			1990	40,995	2,733	15	2,733		32,796	32
33	Folding Walls			1990	13,880	925	15	925		11,103	33
34	Plumbing Improvement			1991	20,830	1,042	20	1,042		11,458	34
35	Elevator Maintenance			1991	61,252	3,063	20	3,063		33,689	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Electric Lock System	1992	$ 21,565	$ 2,156	10	$ 2,156	$	$ 21,565	37
38	Roofing-Laundry Area	1992	43,283	2,164	200	2,164		21,641	38
39	Aluminium Siding - Building A	1992	8,301	553	15	553		5,533	39
40	Electrical Improvement	1993	50,219	3,348	15	3,348		30,132	40
41	Fire Alarm System	1993	239,881	11,994	20	11,994		95,952	41
42	Nurse Call System	1994	106,546	7,103	15	7,103		56,824	42
43	Windows	1995	34,949	2,330	15	2,330		16,310	43
44	Fire Alarm Improvement	1995	8,473	847	10	847		5,931	44
45	Parking Lot Improvement	1995	5,246	350	15	350		2,449	45
46	Roofing Kitchen Area	1995	87,905	4,395	20	4,395		30,766	46
47	Roofing Building B	1995	43,433	2,172	20	2,172		15,202	47
48	Electrical Upgrade	1995	12,081	1,208	10	1,208		8,457	48
49	5th Floor Nursing Station Remodeling	1995	21,392	2,139	10	2,139		14,974	49
50	Elevator Upgrade	1995	21,865	1,093	20	1,093		7,652	50
51	Flooring Shower Room	1995	8,238	549	15	549		3,844	51
52	Fire doors	1995	3,132	157	20	157		1,097	52
53	Computer Cabling	1996	10,804	1,080	10	1,080		6,482	53
54	Floors-Dishroom Storage Room	1996	31,221	2,081	15	2,081		12,488	54
55	Magnetic Doors Locks	1996	6,122	612	15	612		3,673	55
56	Elevator Upgrade	1996	16,500	825	10	825		4,950	56
57	Deaerating Feed Tank	1996	18,600	744	20	744		4,464	57
58	Asphalt Patching	1996	3,462	231	25	231		1,385	58
59	Door Replacement	1996	2,600	173	15	173		1,039	59
60	Removal of Trees/Sod	1996	2,450	98	25	98		588	60
61	5th Floor Heat Upgrade	1996	8,760	584	15	584		3,504	61
62	Caulk/Tuckpoint Windows	1996	80,576	4,029	20	4,029		24,173	62
63	Flashing Building B	1996	4,248	283	15	283		1,699	63
64	Door Alarms	1997	14,222	1,422	10	1,422		7,111	64
65	Walk In Refrigerator Remodeling	1997	9,500	475	20	475		2,375	65
66	Elevator Remodeling	1997	7,747	516	15	516		2,581	66
67	Heat Controls Upgrade	1997	6,637	442	15	442		2,211	67
68	Nursing Station Remodeling	1997	19,000	1,267	15	1,267		6,334	68
69	Roof Repairs	1997	3,000	200		200		1,000	69
70	TOTAL (lines 4 thru 69)		$ 7,632,841	$ 231,354		$ 231,354	$	$ 5,234,072	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,632,841	$ 231,354		$ 231,354	$	$ 5,234,072	1
2	Dryer Filtration System	1997	39,877	1,994	20	1,994		9,970	2
3	Tile Replacement-Building A-Admin	1997	2,401	240	10	240		1,200	3
4	Nursing Station Remodeling	1998	24,122	1,608	15	1,608		6,432	4
5	Boiler Upgrade	1998	54,840	2,742	20	2,742		10,968	5
6	Roof Repair	1998	65,060	4,337	15	4,337		17,349	6
7	Shower Room Floor Repair	1998	39,985	2,666	15	2,666		10,663	7
8	5th Floor Remodeling	1999	98,119	6,541	15	6,541		19,623	8
9	Boiler Upgrade	1999	12,000	600	20	600		1,800	9
10	Security System Upgrade	1999	6,930	693	10	693		2,079	10
11	Concrete Repair	1999	5,000	333	15	333		999	11
12	Plumbing Upgrade	1999	5,000	250	20	250		750	12
13	Courtyard Remodeling	1999	30,000	2,000	15	2,000		6,000	13
14	Landscaping	1999	5,000	333	15	333		999	14
15	Elevator Upgrade	1999	4,200	280	15	280		840	15
16	Smoke Dampers	1999	47,760	3,184	15	3,184		9,552	16
17	Resident Room Remodeling	2000	23,406	1,560	15	1,560		3,120	17
18	Medical Room Remodeling	2000	11,508	767	15	767		1,534	18
19	Rooftop Heater	2000	9,940	994	10	994		1,988	19
20	Windows Laundry	2000	8,264	826	10	826		1,652	20
21	Magnetic Locks	2000	6,750	675	10	675		1,350	21
22	Wandering System	2000	27,929	2,793	10	2,793		5,586	22
23	TV Satellite System	2000	20,398	2,039	10	2,039		4,078	23
24	5th Floor Resident Room Remodeling	2001	49,030	3,269	15	3,269		3,269	24
25	Generators 600KW w/brick enclosure	2001	188,672	5,391	35	5,391		5,391	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,419,032	$ 277,469		$ 277,469	$	$ 5,361,264	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,404,906	$ 222,712	$ 222,712	$	various	$ 982,775	71
72	Current Year Purchases	140,602	16,423	16,423		various	16,423	72
73	Fully Depreciated Assets	25,427					25,427	73
74								74
75	TOTALS	$ 2,570,935	$ 239,135	$ 239,135	$		$ 1,024,625	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident/Employee	97 Dodge Caravan	1997	$ 16,433	$ 3,285	$ 3,285	$	5	$ 16,433	76
77	Resident	97 Chevy Van	1997	32,900	6,580	6,580		5	32,900	77
78	Maintenance	93 Dodge Pickup Truck	1992	17,823				5	17,823	78
79	Resident	00 Ford Bus	2001	96,757	9,676	9,676		10	9,676	79
80	TOTALS			$ 163,913	$ 19,541	$ 19,541	$		$ 76,832	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,159,346	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 536,145	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 536,145	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,462,721	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bulding	$ 180,634	$	$ 180,634	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 180,634	$	$ 180,634	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning N/A
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ none
13.	/2003	$ none
14.	/2004	$ none

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 88

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 56

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$ 19,800	$ 19,800
2	Books and Supplies					
3	Classroom Wages	(a)	2,241	17,234		19,475
4	Clinical Wages	(b)		10,967		10,967
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 2,241	$ 28,201	$ 19,800	$ 50,242
10	SUM OF line 9, col. 1 and 2	(e)	$ 30,442			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	24
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	27

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39 Col 2	108390 # of prescrpts	158,015			962,281	108,390	1,120,296	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Line 10, Col 1&2		6,220			1,322		7,542	12
13	Other (specify): oxygen/PPS expenses	Line 10 & 43					92,715		92,715	13
14	TOTAL			$ 164,235		$	$ 1,056,318	108,390	$ 1,220,553	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Winchester House # 0010678 **Report Period Beginning:** 12/1/2000 **Ending:** 11/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,489,159		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Taxes Receivable	200,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,689,159	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,689,159	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 763,417	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	569,490		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred revenue	200,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,532,907	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,532,907	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,156,252	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,689,159	$	48

***(See instructions.)**

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,504,191	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,504,191	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,872,880)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) Capital Outlay	(475,059)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,347,939)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,156,252	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,886,813	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,886,813	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,465	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	34,975	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	804,653	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	19,027	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 866,120	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	90,992	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90,992	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,843,925	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,426,348	31
32	Health Care	8,047,010	32
33	General Administration	3,032,085	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers	1,211,362	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,716,805	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,872,880)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,872,880)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NA If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 87,181	$ 41.91	1
2	Assistant Director of Nursing	2,080	2,080	75,145	36.13	2
3	Registered Nurses	67,573	76,938	2,101,548	27.31	3
4	Licensed Practical Nurses	25,486	29,991	769,975	25.67	4
5	Nurse Aides & Orderlies	223,767	253,309	3,072,002	12.13	5
6	Nurse Aide Trainees	3,704	3,804	36,297	9.54	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	15,250	18,435	306,831	16.64	8
9	Activity Director	2,080	2,080	45,831	22.03	9
10	Activity Assistants	33,556	29,654	371,630	12.53	10
11	Social Service Workers	7,200	8,356	176,704	21.15	11
12	Dietician	2,080	2,080	45,670	21.96	12
13	Food Service Supervisor	7,926	9,343	318,229	34.06	13
14	Head Cook	12,137	13,789	183,826	13.33	14
15	Cook Helpers/Assistants	47,282	50,797	521,101	10.26	15
16	Dishwashers					16
17	Maintenance Workers	27,568	31,604	566,762	17.93	17
18	Housekeepers	56,165	66,261	746,564	11.27	18
19	Laundry	28,083	33,131	380,596	11.49	19
20	Administrator	2,080	2,080	111,451	53.58	20
21	Assistant Administrator	2,080	2,080	76,789	36.92	21
22	Other Administrative	3,632	4,176	115,498	27.66	22
23	Office Manager					23
24	Clerical	34,610	42,336	644,217	15.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,096	2,080	53,777	25.85	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,952	4,952	90,541	18.28	31
32	Other Health Care(specify)	5,662	6,240	158,015	25.32	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	619,129	697,676	$ 11,056,180 *	$ 15.85	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	120	16,008	9-3	36
37	Medical Records Consultant	96	4,024	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,396	40,296	10a-3	40
41	Occupational Therapy Consultant	586	18,813	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	123	4,665	10a-3	43
44	Activity Consultant	36	1,931	11-3	44
45	Social Service Consultant	28	1,526	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,385	$ 87,263		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,476	$ 144,792	10-3	50
51	Licensed Practical Nurses	144	5,768	10-3	51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)	3,619	$ 150,560		53

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
S. Nussbaum	Administrator	0	$ 111,451
S. Krzciuk	Asst Admin	0	76,789
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 188,240

B. Administrative - Other

Description	Amount
	$
ADL	3,421
Aspen	7,208
Corcom/Voyager	733
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 11,362

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 413,502
Unemployment Compensation Insurance	50,264
FICA Taxes	834,919
Employee Health Insurance	1,453,267
Employee Meals	51,254
Illinois Municipal Retirement Fund (IMRF)*	103,477
Liability Insurance	121,618
Adj to IMRF per PA calculation method	64,770
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,093,071

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,000
(Indicate # of checks performed 83)	
See attached	21,440
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,440

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,927
In-State Travel	
Seminar Expense	10,766
Entertainment Expense	(2,927)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,766

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2000 Ending: 11/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See attached**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **130,558** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **197,100**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **51,254** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **34,975**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Miller & Cooper** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.